

REGISTRATION
MANDATORY PRE-SCREENING AGENT TRAINING
Please Print

Requested Training Date (see training announcement for dates) _____

Are you taking the initial training to satisfy MPA recertification requirements? Yes No

Name (as listed on your license): _____

Agency (if applicable): _____

Business Address: _____

Business Phone: (_____) _____

Business E-mail: _____

Home Address: _____

Home Phone: (_____) _____

Home E-mail: _____

Why are you interested in becoming designated as a MPA?

Are you employed full-time or part-time by a TDMHSAS contracted crisis provider? Yes No

I am a (check all that apply):

- Licensed physician with training, education, or experience in psychiatry Expiration date: _____
- Licensed psychologist designated as a health service provider Expiration date: _____
- Licensed psychological examiner Expiration date: _____
- Licensed senior psychological examiner Expiration date: _____
- Licensed master social worker (LMSW) with two years of mental health experience* (sign statement below) Expiration date: _____
- Licensed clinical social worker Expiration date: _____
- Licensed or certified marital and family therapist Expiration date: _____
- Licensed nurse with a masters degree in nursing who functions as a psychiatric nurse Expiration date: _____
- Licensed professional counselor Expiration date: _____
- Licensed Physician's Asst. with a master's degree & expertise in psychiatry as determined by training, education or experience Expiration date: _____

* As a licensed master social worker, I affirm that _____
I have two (2) years of mental health experience. LMSW Signature

Signature: _____ Date: _____